BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: TINA MARIE ENGLE 2459 Tulip Street Fairfield, CA 94533 Registered Nurse License No. 481640 Public Health Nurse Certificate No. 54845 Respondent.	Case No. 2012-306 OAH No. 2012040526

DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Board of Registered Nursing as its Decision in the above-entitled matter.

This Decision shall become effective on January 14, 2013.

IT IS SO ORDERED this 14th day of December, 2012.

Raymond Mallel, President
Board of Registered Nursing
Department of Consumer Affairs
State of California

BEFORE THE
BOARD OF REGISTERED NURSING
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STATE OF CALIFORNIA

In the Matter of the Accusation Against: TINA MARIE ENGLE, Registered Nurse License No. 481640 Public Health Nurse Certificate No. 54845 Respondent.	Case No. 2012-306 OAH No. 2012040526

PROPOSED DECISION

Administrative Law Judge Jill Schlichtmann, State of California, Office of Administrative Hearings, heard this matter on September 11, 12 and 13, 2012, in Oakland, California.

Leslie E. Brast, Deputy Attorney General, represented complainant, Louise R. Bailey, M.Ed., R.N., the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs for the State of California.

Deborah L. Phillips, Attorney at Law, represented Tina Marie Engle, who was present throughout the administrative hearing.

The matter was submitted for decision on September 13, 2012.

FACTUAL FINDINGS

1. Louise R. Bailey, M.Ed., R.N., made the amended accusation against Tina Marie Engle (respondent) in her official capacity as the Executive Officer of the Board of Registered Nursing (Board).

2. On August 31, 1992, the Board issued Registered Nurse License No. 481640 to respondent. On November 28, 1995, the Board issued Public Health Nurse Certificate No.

54845 to respondent. Both respondent's license and certificate were in full force and effect at all times relevant and are scheduled to expire on April 30, 2014, unless renewed.

3. In its initial accusation, the Board alleged that respondent had committed unprofessional conduct and/or gross negligence when following the cardiopulmonary arrest of a patient she was caring for, she removed the medical equipment used to monitor and record the patient's vital signs. In its amended accusation, the Board limited the cause for discipline to respondent's criminal conviction for grand theft of the medical equipment.

At hearing, evidence of respondent's conduct in responding to the patient's cardiopulmonary arrest was offered by both parties, and opinions about whether that conduct violated the standard of care, were offered by experts testifying at the request of both parties. Only the evidence that is relevant to whether respondent's criminal conviction constitutes cause for discipline, and evidence that is relevant to the appropriate level of license discipline, will be considered in reaching the legal conclusions in this matter.

Respondent's Criminal Conviction

4. On May 2, 2012, in the Superior Court of California, County of San Francisco, respondent was convicted of violating Penal Code section 487, subdivision (a) (grand theft). Imposition of sentence was suspended and respondent was placed on unsupervised probation for a period of three years on conditions that included serving two days in county jail, and paying various fines and assessments.

Factual Circumstances underlying Respondent's Conviction

5. Plastic surgeon, Donald Brown, M.D., performed cosmetic surgery on Patient GG on August 18, 2008. Patient GG was a personal friend of Dr. Brown's, was in excellent health, and had been cleared for the surgery by a cardiologist.

6. The surgery took place in an operating room in Dr. Brown's office suite. The office suite also contains a recovery room and a reception room. The office suite is adjacent to California Pacific Medical Center (CPMC).

7. For certain types of surgeries, Dr. Brown would hire a nurse and a nursing assistant to monitor the patient in the recovery room overnight. The overnight recovery nurse is responsible for caring for the patient, monitoring the patient's vital signs, and contacting the physician immediately in the event of a medical complication.

8. Dr. Brown had hired respondent as an overnight recovery nurse regularly beginning in 1999, and had been satisfied with her services. Dr. Brown hired respondent and a certified nursing assistant, Carina Flores, to monitor Patient GG overnight after his surgery.

9. Dr. Brown finished Patient GG's surgery at approximately 6:45 p.m. Patient GG's heart rate was steady during the surgery and the procedure had gone well. Respondent

arrived at the office as the surgery was ending. After the surgery, anesthesiologist Bernard Millman, M.D., and respondent, took over the post-operative care of Patient GG. Dr. Millman administered Thorazine[1] to Patient GG for restlessness at 7:15 p.m.

10. Once in the recovery room, Patient GG was connected to an electronic monitor which measures and records the patient's vital signs, including the oxygen saturation level, pulse and blood pressure. If the patient's oxygen saturation level dips to a dangerous level, the monitor beeps loudly and continuously. The vital sign measurements are recorded on a continuous loop by the monitor. The stored information is recorded over after a period of time, if the machine is left running.

11. Dr. Brown remained in the office until approximately 8:00 p.m. Before leaving, he checked on Patient GG, who was awake but heavily sedated. Concluding that Patient GG was stable, Dr. Brown left the office. Dr. Millman left the office shortly afterward, leaving Patient GG in respondent's care.

12. At 8:10 p.m., respondent administered Thorazine to Patient GG for increased restlessness. Ten minutes later, respondent administered Demerol[2] to Patient GG for restlessness.

13. After arriving at home, Dr. Brown called respondent to check on Patient GG. Respondent was on the phone with Dr. Millman at the time. Respondent assured Drs. Brown and Millman that Patient GG was stable and resting comfortably. Respondent hung up the telephone at approximately 9:29 p.m.

14. Respondent and Flores reported that as soon as respondent hung up with Dr. Millman they heard Patient GG's monitor beeping. According to respondent, when she heard the monitor beeping, she jumped up and went to the patient's bedside, which was located eight to 10 feet away. Patient GG was pale and unresponsive, and his pupils were dilated. Respondent reported shaking Patient GG, and trying to sit him upright, but he remained unresponsive. Next respondent tried using an "Ambu bag" to resuscitate Patient GG.[3] Respondent reports having been unable to obtain a good seal on Patient GG's mouth and abandoning the device. Respondent did not find a full oxygen tank in the crash cart next to Patient GG, so she tried using a long tube from the operating room but was unsuccessful. Ultimately, respondent attempted mouth-to-mouth resuscitation. Flores placed a 911 call

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[1] Thorazine is the trade name for Clorpromazine, a sedative.

[2] Demerol is the trade name for Meperidine hydrocloride, an opioid pain reliever.

[3] An "Ambu bag" is the trade name for a hand-held device used to resuscitate a patient in respiratory distress or respiratory arrest. It consists of a face mask and an air chamber. When the face mask is properly attached, and the air chamber is squeezed, it forces air into the patient's lungs.

from Dr. Brown's office suite at 9:36 p.m. An emergency team arrived from CPMC by 9:40 p.m.

15. When the CPMC emergency team arrived, they took over Patient GG's care. The emergency crew removed Patient GG from the office monitor, connected him to their portable monitor and transported him to CPMC. It was later determined that Patient GG had suffered a brain injury due to a prolonged lack of oxygen. Patient GG died after being taken off of life support on August 21, 2008.

The Investigation into the Patient GG's Demise

16. Dr. Brown received an emergency call at home from Patient GG's wife, advising him that her husband was in cardiac arrest and at CPMC. Dr. Brown rushed to CPMC, where the scene in the ICU was chaotic. The doctors attending to Patient GG were confused about his condition because he had been in excellent health. Dr. Brown collaborated with the cardiologists, who were trying to determine what had happened, evaluate Patient GG's status, and plan his treatment. Dr. Brown and the cardiologists asked respondent what had occurred, and what Patient GG's vital signs had been leading up to the emergency. Respondent was unable to recall Patient GG's vital signs prior to him being found unresponsive. The vital sign data would have assisted the physicians attending to Patient GG in understanding why he was unresponsive and what could be done to help him.

17. Dr. Brown later returned to his office and sat down with respondent and Flores. He questioned them about what had occurred. He asked each nurse to write a statement of exactly what they remembered. He separated the nurses so that they would describe the event independently. Dr. Brown then returned to CPMC to check on Patient GG.

18. Later that night, at around 4:00 or 5:00 a.m., Dr. Brown returned to his office. Respondent reiterated that she could not recall the vital signs before the emergency. She told Dr. Brown that she had given Patient GG mouth-to-mouth resuscitation. Dr. Brown could not understand why respondent would have chosen mouth-to-mouth resuscitation instead of the other modalities available in the office, which were more effective than mouth-to-mouth resuscitation. He was very angry and emotional. Indeed, Dr. Brown accused respondent of murdering his friend and patient.

19. Dr. Brown suggested that they review the chart notes to go over the details of what had occurred. Respondent told him that her chart notes were missing. Dr. Brown then suggested that they review the monitor readings. He then discovered that the monitor was missing as well. Respondent told Dr. Brown that she did not know where the monitor was located. Dr. Brown asked Flores what she knew about the monitor. Flores stated that after the emergency team and respondent left with Patient GG, she cleaned up. She recalled picking the monitor up from the floor, cleaning it off and returning it to the cart where it belonged. Dr. Brown and respondent returned to CPMC and searched everywhere for the chart notes and the missing monitor, to no avail.

20. Dr. Brown contacted the emergency personnel and was told that they used their portable monitor and did not take his monitor to CPMC.

21. Dr. Brown asked the office building security if he could view the security footage of the building lobby from the night before. The videotape revealed respondent and Flores entering the lobby at about 1:30 a.m. Respondent was seen leaving the building with a large bag on her shoulder and returning 10 to 15 minutes later. Flores opened the locked entrance door for her and they returned to Dr. Brown's office. Dr. Brown concluded that respondent had stolen the monitor and chart notes, and the police were contacted.

22. The San Francisco Medical Examiner's office conducted an investigation into Patient GG's death. Judy Melinek, M.D., who is board certified in anatomic and clinical pathology, and forensic pathology, was assigned to the investigation. Dr. Melinek conducted the autopsy and interviewed witnesses before reaching her conclusions about the manner of Patient GG's death. When Dr. Melinek interviewed Dr. Brown, she was stunned to learn that the nurse monitoring Patient GG did not recall his vital signs prior to the emergency, and that the chart notes and monitor were missing. As a result of this information, the Medical Examiner's office contacted the San Francisco District Attorney's office to initiate a criminal investigation.

23. Nine or ten months after Patient GG's death, respondent returned the monitor to the San Francisco District Attorney's office. There was no data on the monitor when it was returned.

24. The lack of information about Patient GG's vital signs before the emergency made Dr. Melinek's investigation very difficult. The vital signs are important clues in determining how someone dies. Dr. Melinek initially had to determine whether Patient GG had died of a cardiac arrest or a pulmonary arrest. This initial determination guides the rest of the investigation. Monitor and chart data would have aided Dr. Melinek in reaching a conclusion as to the cause of death. In addition, the monitor data would have answered how much time had elapsed before Patient GG was resuscitated. Dr. Melinek had never before encountered a case in which a nurse failed to provide any information about a patient's vital signs preceding an emergency.

25. After a lengthy and thorough investigation, in December 2008, Dr. Melinek determined that Patient GG had died of anoxic-ischemic encephalopathy, a lack of oxygen combined with reduced blood flow to the brain, causing brain damage. Dr. Melinek concluded that the anoxic-ischemic encephalopathy was due to "probable respiratory arrest." In light of the lack of information surrounding the death, she found the manner of death to be "undetermined." After reviewing deposition testimony and telephone records, in December 2010, Dr. Melinek was able to confirm that Patient GG had died of respiratory arrest due to a prolonged period without oxygen and to assign a manner of death.

26. Dr. Melinek had serious concerns about: 1) the disappearance of the chart notes and monitor; 2) the absence of data on the monitor once it was recovered; 3) the

inability of respondent to recall the vital signs when initially questioned; and, 4) the inconsistency between respondent's and Flores's estimation of the time between the patient's arrest and their call for help, and the documented phone records and clinical impression of actual "down time." Dr. Melinek found respondent's theft of the monitor to demonstrate an utter lack of integrity, and she contacted the Board to initiate an investigation.

27. The Board consulted with Michele Hackett, R.N., to evaluate respondent's conduct in response to Patient GG's emergency. Hackett opined that respondent's theft of the monitor constituted an extreme departure from the standard of care because 1) the theft of a medical monitor could have jeopardized patient care; 2) it constituted a failure to advocate for the patient; and 3) information on the monitor could have contributed to an understanding of what had occurred to the patient.

Costs of Investigation and Prosecution

28. The Board certifies that the following costs were reasonably incurred in connection with the investigation and prosecution of this Accusation:

Board Division of Investigation:	
2008-2009: 1 hour @ $192 per hour	$ 192.00
2009-2010: 30.25 hours @ $159 per hour	$ 4,809.75
2010-2011: 32.25 hours @ $161 per hour	$ 5,192.25
2011-2012: .50 hours @ 161 per hour	$ 80.50
Total Board Investigation Costs:	$10,274.50
Board Expert Witness Fees:	
2010-2011: 10.7193 hours @ 75 per hour	$ 803.95
Total Investigative Costs:	$ 11,078.45
Department of Justice Fees:	
Attorney General Fees	
43.25 hours @ $170 per hour	$ 7,352.50
Paralegal Fees	
2.75 hours @ $120 per hour	$ 330.00
Total Prosecution Fees:	$ 7,682.50
TOTAL FEES AND COSTS:	$18,760.95

Respondent's Evidence

29. Respondent received a medical assistant certificate after attending a program in high school in 1984. She obtained a vocational nurse certificate in 1991. Respondent obtained an Associate of Science degree in nursing from Pacific Union College in 1992. She earned her Public Health Nurse certificate in 1995, and earned her Bachelor of Science degree in 1995.

30. From 1994 until 2003, respondent worked as a per diem nurse in acute inpatient psychiatric hospitals and medical surgical units. From 2003 until the present, respondent has worked at St. Francis Memorial Hospital as a per diem staff nurse in the inpatient medical-surgical and acute psychiatric units.

Respondent's work evaluations from St. Francis Memorial Hospital between 2009 and 2012, demonstrate that respondent has met or exceeded her supervisor's expectations in almost all categories.

31. Respondent has kept her Basic Life Support (BLS) and Advanced Cardiovascular Life Support (ACLS) certifications current. Respondent completed seven hours of continuing education in assault prevention training in 2010. In 2012, respondent completed a 27-hour course on cancer in women, and a 3-hour course on fibromyalgia in women.

32. Between 1999 and the present, respondent has worked as a per diem nurse to select plastic and reconstructive surgery clinics, such as Dr. Brown's office. She has provided recovery, post-operative private duty, and in-home after care services. Respondent continues to provide these services to one plastic surgery clinic in San Francisco.

33. Between 1993 and 1999, respondent worked as a circulating nurse and recovery room nurse for plastic surgeon Leslie Moglen, M.D., F.A.C.S., in San Francisco. While working for Dr. Moglen, respondent handled medication inventory and ordering, and performed post-operative nursing care. Dr. Moglen trained respondent in the care of plastic surgery patients and in the administration of conscious sedation.

On September 26, 1996, a major emergency occurred during a cosmetic surgery performed by Dr. Moglen on a patient (Patient JH) in his office-based operating room. Respondent had been assigned to assist Dr. Moglen in the surgery. Respondent reports that after she administered Demerol to Patient JH as directed by Dr. Moglen, the patient's heart rate plunged. Dr. Moglen tried to stimulate Patient JH, but her heart rate and vital signs continued dropping. They called 911 and tried to manage the emergency. The 911 emergency crew arrived and transported Patient JH to the hospital, where she later died.

A civil suit was filed against respondent and Dr. Moglen. Respondent was told that Dr. Moglen did not have malpractice insurance, and as a result, she feels she was unfairly blamed for Patient JH's death. Her malpractice insurer paid out a substantial sum on a claim

filed by Patient JH's family, which prompted a Board investigation. Respondent was required to attend numerous hearings, a trial, and the coroner's inquest. Dr. Moglen eventually lost his license to practice medicine in 1999.

The Board filed an accusation against respondent as a result of her involvement in Patient JH's care. In May 2005, the Board withdrew the accusation.

Respondent reports having lived her life under the cloud of Patient JH's death from 1996 until the Board withdrew its accusation in 2005.

34. Respondent states that when Dr. Brown returned to the office suite with her after conferring with the cardiologists, he was very emotional and very angry. Respondent states that Dr. Brown was yelling at her, and at Flores, using profanity and banging his hands on the wall. Respondent states that for reasons that she does not understand, she kept thinking that she should take the monitor. After Dr. Brown returned to CPMC, respondent reports that she placed the monitor in her overnight bag. She asked Flores to accompany her to the lobby so that she could retrieve her cell phone from her car, then Flores could let her back into the locked building. Respondent hid the monitor in her car. She next left the monitor at her boyfriend's home overnight; later she moved it to her mother's home, where she hid it in a bag of kitty litter in the garage. Respondent states that she did not erase data from the monitor. She eventually returned the monitor to her counsel. Respondent regrets having taken the monitor.

35. Respondent reports having attended some individual therapy in the fall of 2011. She has been compliant with her probation, has paid the fines and released her bond.

Character Evidence

36. Tatyana K. Ferrier, a coworker of respondent's at St. Francis Memorial Hospital, wrote a character letter for respondent. Ferrier has found respondent to consistently carry out her nursing responsibilities in a competent and compassionate manner. Ferrier considers respondent's work to demonstrate the highest moral and ethical, personal and professional, standards. Ferrier does not reference respondent's criminal conviction in her letter.

37. Roberto Moran, a certified nursing assistant who has worked with respondent since 1995, wrote a character letter and testified on respondent's behalf. Moran has observed respondent to exhibit a very positive attitude, and to be a great team player. He considers respondent to be very professional, reliable, and always alert to her patients' needs.

When Moran first met respondent, he worked in security. He has never had a concern about respondent committing a theft. St. Francis has a "zero tolerance" for employee theft.

Later, Moran worked as a certified nursing assistant and mental health partner in the Behavioral Health Unit with respondent. In this position, his job is to assist the registered

nurses and keep the patients safe. Moran once witnessed respondent save a patient's life by cardiopulmonary resuscitation. Moran finds respondent to be professional and compassionate with her patients. Moran and respondent socialize together on occasion. He is aware of her criminal conviction, but it does not change his opinion of her.

38. Lynda Hurley, a registered nurse since 1969, submitted a character letter and testified on respondent's behalf. Hurley has been the Director of the Operating Room for a plastic surgery facility similar to Dr. Brown's. Hurley has known respondent for more than 10 years and has worked with her as a colleague and as her supervisor. She regularly reviewed respondent's charting when respondent served as a post-operative and overnight nurse for the office's plastic surgery patients. Hurley has found respondent's charting to reflect a thorough initial assessment, continued close monitoring of vital signs, alertness for potential complications and appropriate interventions for patient care. Hurley has received favorable comments from patients regarding respondent's overnight care. Hurley has no reservations about respondent's nursing ability.

Hurley is aware of respondent's criminal conviction. She does not believe that respondent would take a monitor again. Hurley believes that Dr. Brown's anger triggered respondent's decision to take the monitor. In Hurley's opinion, the monitor would not have any valuable information for the physicians caring for the patient; she believes that the patient's vital signs preceding the emergency constituted anecdotal information which would not alter the patient's care, however she has not discussed the particulars of the patient's care with anyone. Hurley has not worked with respondent since this incident because the plastic surgeon for whom she works has not allowed respondent to work in his office after he learned about respondent's theft of the monitor.

39. Donald Rasmussen, respondent's boyfriend of 15 years, testified as a character witness for respondent. Rasmussen has worked as a peace officer with the San Francisco Probation Department for four years. He is assigned to the Juvenile Justice Center. His job duties include supervising detainees and transporting them to court and to other locations. Rasmussen previously worked as a peace officer with the San Mateo Probation Department for eight years.

Rasmussen and respondent live together part-time and he knows her well. He is aware that respondent removed a piece of medical equipment and that she has been convicted of misdemeanor theft as a result. Rasmussen believes that respondent's act in removing the monitor was out of character. He believes that she panicked, but feels she did the right thing by ultimately returning it. Rasmussen has no reason to believe that respondent will do something like that again. Respondent has expressed remorse about the incident. He never saw the monitor and does not know if she ever turned it on. Rasmussen believes that respondent has paid the price for her conduct emotionally and financially. Rasmussen considers respondent to be a conscientious and good person, and a hard worker. He believes she should be forgiven for this transgression.

40. Respondent provided a letter of recommendation from Riva T. Berelson, the wife of a patient for whom respondent provided ongoing services as a private duty nurse. Berelson praises respondent's attitude and nursing abilities. There is no mention of respondent's conviction in Berelson's letter.

41. Respondent provided copies of several thank you letters praising her care that she has received from patients over the years.

Expert Testimony from John Watts Podboy, Ph.D.

42. Respondent offered expert testimony from John Watts Podboy, Ph.D., a clinical and forensic psychologist. Dr. Podboy has been licensed in California since 1981 and has been in private practice since 1978. Dr. Podboy has worked as a consultant since 1997.

Dr. Podboy examined respondent on five occasions. As part of his examination, Dr. Podboy administered a 21-page medical and psychological questionnaire, a traumatic stress inventory, the Minnesota Multi-Phasic Personality Inventory – 2, and the Wechsler Abbreviated Scale of Intelligence, Second Edition. Dr. Podboy reviewed and considered records from the Board's investigation, the Medical Examiner's records and Dr. Melinek's deposition testimony, discovery records from the San Francisco District Attorney's office, and notes of Inspector T. Newland regarding Patient GG's death. Dr. Podboy also interviewed respondent's brother and spent time conferencing with respondent by telephone and email.

During his investigation into this matter, Dr. Podboy learned that respondent's father had been an alcoholic who turned violent when he was intoxicated. Respondent's father physically abused her, her brother and her mother. After he died, respondent's brother continued the cycle of physical abuse toward respondent. Respondent and her brother have since healed their relationship. Respondent's brother is now an anesthesiologist and resides in Los Angeles.

Dr. Podboy learned that respondent felt unjustly blamed for Patient JH's death. The legal proceedings and Board investigation caused her a significant amount of stress over a long period of time.

Dr. Podboy concluded that respondent is a highly competent nurse who suffers from post-traumatic stress disorder as a result of a traumatic childhood, and being unfairly blamed for the 1996 death of Patient JH. Dr. Podboy views respondent's theft of the monitor as a response to Dr. Brown's outburst, and because she felt she was going to be blamed for Patient GG's demise.

Dr. Podboy opines that respondent's theft of the monitor was an isolated incident that "will undoubtedly never occur again" because respondent intends to terminate her work in post-operative care. Dr. Podboy concluded that there are "absolutely no psychological

barriers to [respondent] continuing as a psychiatric professional or in other nursing services for which she is qualified based on her training and experience."

LEGAL CONCLUSIONS

1. Business and Professions Code section 490, subdivision (a), authorizes the discipline of a license where the licensee has been convicted of an offense that is substantially related to the qualifications, functions or duties of the licensed profession. Business and Professions Code section 2761, subdivision (f), authorizes the Board to take disciplinary action against a licensee for a conviction of an offense that is substantially related to the qualifications, functions or duties of a registered nurse. Pursuant to the Board's regulations, a conviction is substantially related to the qualifications, functions or duties of a registered nurse if it evidences the present or potential unfitness of a registered nurse to practice in a manner consistent with the public health, safety or welfare. (Cal. Code Regs., tit. 16, § 1444.)

2. The theft of a medical monitoring device used to record a patient's vital signs, while the patient is in distress, is substantially related to the practice of nursing because it evidences the present or potential unfitness of a registered nurse to practice in a manner consistent with the public health, safety or welfare.

3. By reason of the matters set forth in Factual Findings 4 and 34, respondent's conviction constitutes cause for discipline pursuant to Business and Professions Code sections 490, subdivision (a), and 2761, subdivision (f).

4. Pursuant to the Board's disciplinary guidelines,[4] the recommended discipline for the conviction of a substantially related offense is revocation of the license. In determining whether revocation, suspension or probation is to be imposed in a given case, factors such as the following should be considered: 1) the nature and severity of the act or crime under consideration; 2) actual or potential harm to the public; 3) actual or potential harm to a patient; 4) prior disciplinary record; 5) the number and/or variety of current violations; 6) mitigation evidence; 7) rehabilitation evidence; 8) compliance with conditions or probation; 9) the licensee's overall criminal record; 10) the amount of time that has passed since the act or offense; and 11) expungement proceedings pursuant to Penal Code section 1203.4.

In this matter, the nature of respondent's criminal conviction is aggravated because it directly involved a nurse's obligation to provide care for her patients. The conduct can only be described as severe. Respondent's decision to remove her patient's vital sign monitor demonstrated that she was more concerned about consequences to her than to her patient. The attending physicians' inability to obtain information from the monitor may have impacted their ability to care for the patient. It would have assisted them in understanding

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[4] California Code of Regulations, title 16, section 1444.5.

what had occurred and what the patient's family could expect in the future. (Factual Finding 16.) The information also would have assisted the medical examiner in determining how and why the patient went into cardiopulmonary arrest. (Factual Findings 22 and 24.) This was information that the physicians and the family had a right to obtain. Respondent's concealment of the monitor resulted in harm to Patient GG and his family members.

As stated in Business and Professions Code section 2708.1, in determining the appropriate license discipline, protection of the public is the Board's paramount concern. Respondent established that she had a difficult childhood, and she felt unjustly blamed for the death of Patient JH. In Dr. Podboy's opinion, these past experiences help to explain her decision to steal the monitor. (Factual Finding 42.) Notwithstanding Dr. Podboy's explanation of respondent's behavior, respondent acted in a manner that put her needs ahead of her patient's, in direct contravention with a nurse's obligations. In addition, respondent was dishonest when questioned about what happened to the monitor. (Factual Finding 19.) Her behavior demonstrated a lack of integrity, and a lack of concern for her patient and his family. Evidence was not presented from which the Board could have confidence that respondent would act differently in the future. Under the evidence presented, there is no justification for deviating from the Board's guidelines. The safety and welfare of the public warrants revocation of respondent's registered nurse license and public health nurse certificate.

5. Complainant has requested that respondent be ordered to reimburse the Board for the costs of enforcing the accusation. Business and Professions Code section 125.3 provides that respondent may be ordered to pay the Board "a sum not to exceed the reasonable costs of the investigation and enforcement of the case." The Board reasonably incurred costs of investigation and enforcement in the amount of $18,760.95. (Factual Finding 27.) In *Zuckerman v. State Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, the California Supreme Court set forth the guidelines for the determining whether the costs should be assessed in the particular circumstances of each case. The *Zuckerman* court stated:

> The Board must exercise its discretion to reduce or eliminate cost awards in a manner that will ensure that [the cost award provision] does not deter [licensees] with potentially meritorious claims or defenses from exercising their right to a hearing. Thus the Board must not assess the full costs of investigation and prosecution when to do so will unfairly penalize a [licensee] who has committed some misconduct, but who has used the hearing process to obtain a dismissal of other charges or a reduction in the severity of the discipline imposed.

Respondent has not established a basis upon which to reduce the costs incurred by the Board.

ORDER

Registered Nurse License No. 481640, and Public Health Nurse Certificate No. 54845, issued to respondent Tina Marie Engle, are revoked.

If and when respondent's license is reinstated, she shall pay to the Board costs associated with its investigation and enforcement pursuant to Business and Professions Code section 125.3 in the amount of $18,760.95. Respondent shall be permitted to pay these costs in a payment plan approved by the Board. Nothing in this provision shall be construed to prohibit the Board from reducing the amount of cost recovery upon reinstatement of the license.

DATED: 10/11/12

JILL SCHLICHTMANN
Administrative Law Judge
Office of Administrative Hearings

Exhibit A

First Amended Accusation Case No. 2012-306

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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: **TINA MARIE ENGLE** **2459 Tulip Street** **Fairfield, California 94533** **Registered Nurse License No. 481640** **Public Health Nurse Certificate No. 54845** Respondent.	Case No. 2012-306 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant), brings this First Amended Accusation (Accusation) solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing (Board), Department of Consumer Affairs.

2. On or about August 31, 1992, the Board issued Registered Nurse (RN) License Number 481640 to Tina Marie Engle (Respondent). On or about November 28, 1995, the Board issued Public Health Nurse (PHN) Certificate Number 54845 to Respondent. Both Respondent's RN license and PHN certificate were in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2014, unless renewed.

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JURISDICTION

3. This First Amended Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Code section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. The Board may renew an expired license pursuant to the provisions of Code section 2811.

STATUTORY/REGULATORY PROVISIONS

6. Code section 490 provides, in pertinent part, that a board may suspend or revoke a license on the ground that the licensee has been convicted of a crime substantially related to the qualifications, functions, or duties of the business or profession for which the license was issued.

7. Code section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

. . .

"(f) Conviction of a felony or of any offense substantially related to the qualifications, functions, and duties of a registered nurse, in which event the record of the conviction shall be conclusive evidence thereof."

8. California Code of Regulations, title 16, section 1444, sets forth the Board's substantial relationship criteria, as follows:

"A conviction or act shall be considered to be substantially related to the qualifications, functions or duties of a registered nurse if to a substantial degree it evidences the present or potential unfitness of a registered nurse to practice in a manner consistent with the public health,

safety, or welfare. Such convictions or acts shall include but not be limited to the following:

"(a) Assaultive or abusive conduct including, but not limited to, those violations listed in subdivision (d) of Penal Code Section 11160.

"(b) Failure to comply with any mandatory reporting requirements.

"(c) Theft, dishonesty, fraud, or deceit.

"(d) Any conviction or act subject to an order of registration pursuant to Section 290 of the Penal Code."

COST RECOVERY

9. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

CAUSE FOR DISCIPLINE

(Conviction of a Substantially Related Crime)

10. Respondent is subject to disciplinary action under Code sections 490 and 2761, subsection (f), for unprofessional conduct in that she was convicted of a crime substantially related to the qualifications, functions and duties of a registered nurse, as follows:

11. On or about May 2, 2012, in San Francisco Superior Court, case number 217085, Respondent was convicted of having violated Penal Code section 487(a) (grand theft). Respondent's conviction arose from her theft on or about August 19, 2008, of a medical monitoring device used to monitor and record the vital signs of a post-surgical patient who went into cardiopulmonary arrest while in Respondent's care. The circumstances are described below.

12. On or about August 18, 2008, Respondent was working as a recovery nurse in an outpatient surgical center adjacent to California Pacific Medical Center in San Francisco. Her responsibilities included the post-operative care of a 63-year-old male patient who had undergone a lengthy plastic surgery. While in Respondent's care, the patient went into cardiopulmonary arrest. He was transfered to the hospital where he subsequently died on August 21, 2008. The monitor would have measured and recorded the patient's vital signs during his recovery from

surgery, including his pulse, oxygen saturation, blood pressure, and respirations. This data was important to understanding the patient's post-operative respiratory failure, cardiac arrest, anoxic brain injury and subsequent death.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 481640, issued to Tina Marie Engle (Respondent);

2. Revoking or suspending Public Health Nurse Certificate Number 54845 issued to Respondent;

3. Ordering Respondent to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

4. Taking such other and further action as deemed necessary and proper.

DATED: July 17, 2012

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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